LEGISLATING FOR THE PROVISION OF COMPREHENSIVE SUBSTANCE ABUSE TREATMENT PROGRAMS FOR PREGNANT AND MOTHERING WOMEN

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I. INTRODUCTION

In the previous two articles that this author has written on the subject of drug and alcohol-exposed children,[1] she has argued that a key element to preventing children from being exposed *in utero* to drugs or alcohol is the provision of efficacious, comprehensive substance abuse treatment programs for pregnant and mothering women. The purpose of this article is to explore this element in depth in order to provide further guidance to the states in their creation of such programs.

In order to provide an in-depth look at programs and legislation in the area of treatment for pregnant and parenting women, this article will discuss national trends, but will also focus more deeply on a few individual states, namely California, Oregon and Washington. The article will demonstrate that although progress has been made in creating greater access to comprehensive drug treatment programs for pregnant and mothering women, certain legislative action is needed to further improve this access. Additionally, in writing this article it became clear that, although the data collection in this area has improved over the past twenty years, more specific data is needed in order to have a clearer picture of the exact nature of the unmet need so that the states can better address it. Thus, although the authors were able to obtain enough

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1. Janet W. Steverson, *Stopping Fetal Abuse with No-Pregnancy and Drug Treatment Probation Conditions*, 34 SANTA CLARA L. REV. 295 (1994) (hereinafter Steverson, *Stopping Fetal Abuse*); Janet W. Steverson, *Prenatal Drug Exposure: The Impetus for Overreaction by the Legal Community or a Serious Problem Needing a Serious Solution?*, 28 CHILD. LEGAL RTS. J. 41 (2008) [hereinafter Steverson, *Prenatal Drug Exposure*].

information to provide some suggestions to the states for providing treatment programs for pregnant and mothering women, work in the area is severely limited by the lack of accessible data.

II. THE LEVEL OF NEED FOR COMPREHENSIVE DRUG TREATMENT PROGRAMS FOR PREGNANT AND PARENTING WOMEN

As this author explained in a previous article,[2] a woman's use of drugs or alcohol during pregnancy often causes serious, and in many cases severe, physical and behavioral problems for the exposed child.[3] In order to protect as many children as possible from such harm, the states need to put in place a system that involves collaboration between their respective healthcare (including drug and alcohol treatment programs), welfare, and criminal justice systems.[4] An essential element of this collaborative system is the provision of comprehensive treatment services.[5] Such services are essential because many of the women who prenatally expose their infants to alcohol or drugs are addicted and thus need assistance in overcoming this addiction.[6] Appropriate treatment programs can provide this assistance, as demonstrated by a large body of evidence indicating that if women can obtain effective substance abuse treatment services, a majority of them will be able to improve their circumstances in many different ways.[7] For example, in Oregon for the fiscal year 2005–06, the Oregon Addictions and Mental Health Division reported that by the end of treatment, 49% of children were returned to parents who received treatment; 66% of abusers were employed; 72% of abusers had reduced their use and 73% of the abusers who started treatment completed treatment.[8] Further,

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2. Steverson *Prenatal Drug Exposure*, *supra* note 1.

3. *Id.* at 42.

4. *Id.* at 50. For a complete discussion of the proposed state initiative see Steverson, *Prenatal Drug Exposure*, *supra* note 1, at 50–54.

5. *Id.* at 50. Other commentators have advocated for increased numbers of comprehensive treatment services for pregnant and mothering substance abusers. *See, e.g.*, Elizabeth E. Coleman & Monica K. Miller, *Assessing Legal Responses to Prenatal Drug Use: Can Therapeutic Responses Produce More Positive Outcomes than Punitive Responses?*, 20 J. L. & HEALTH 35, 62 (2007); Rommel Cruz, *The Greatest Source of Wealth: Washington State's Response to Prenatal Substance Abuse*, 41 GONZ. L. REV. 1, 11 (2005-2006); Luis B. Curet, *Drug Abuse During Pregnancy*, 45 CLINICAL OBSTETRICS AND GYNECOLOGY 73, 77 (2002); Barry M. Lester et al., *Substance Use During Pregnancy: Time for Policy to Catch up with Research*, 1 HARM REDUCTION J. 1, 26 (2004), *available at http://* www.harmreductionjournal.com/content/1/1/5.

6. Lynn M. Paltrow, David S. Cohen, & Corinne A. Carey, *2000 Overview: Governmental Responses to Pregnant Women Who Use Alcohol or Other Drugs*, WOMEN'S LAW PROJECT 1, http:// advocatesforpregnantwomen.org.

7. Embry Howell et al., *A Review of Recent Findings on Substance Abuse Treatment of Pregnant Women,* 16 J. OF SUBSTANCE ABUSE 193, 210 (1999) ("Women who complete treatment have a greater likelihood of reducing their substance use than those who do not complete treatment.").

8. For example, in Oregon the Addictions and Mental Health Division of the Department of Human Services indicates that "overall outcomes for those persons receiving services are quite good." ADDICTIONS AND MENTAL HEALTH DIVISION (AMH) UPDATE: PERFORMANCE MEASURES FOR TREATING SUBSTANCE ABUSE, (2007), http://egov.oregon.gov/DHS/addiction/publications/fact-sheets/fs-pm4treat-sub-abuse-dhs.pdf. For example, for fiscal year 2005–06, 49% of children by the end of treatment were returned to parents; 66% of abusers were employed; 72% of abusers had reduced their use; and 73% of abusers were retained in treatment. *Id.*

the 2006 National Outcomes Measure for Oregon reported a decreased homelessness rate for those receiving treatment.[9]

Thus, in order to protect as many children as possible from prenatal drug or alcohol exposure, the state must ensure that a sufficient number of appropriate treatment programs exist for all pregnant and mothering substance abusers. In addition, it must ensure that the women can expeditiously access those programs. However, in putting together a plan for the provision of efficacious treatment programs, one must first attempt to assess whether there is an unmet need for such services. This section will make that assessment by first explaining the types of programs that are needed and why they are needed. Data will then be presented to demonstrate that, although the past twenty years have seen an increase in necessary services, a significant number of pregnant and parenting women are not being served. Several factors contribute to this unmet need. First, there continues to be an inadequate supply of the necessary programs, and second, for a variety of reasons, many pregnant and parenting women encounter difficulties in accessing the needed services.

A. Types of Programs Needed

Fairly recent developments in the field of drug abuse treatment have provided increasing insight into the types of drug treatment programs that work most effectively for women in general, and for pregnant and parenting women in particular. The necessary components of such programs are outlined below. In examining these components we can better determine what legislative and regulatory scheme will best effectuate the desired treatment outcomes.

1. Overcoming Barriers

Effective programs must be able to address the unique characteristics of substance-abusing women in general and pregnant and parenting women in particular. Most women who abuse alcohol and illicit substances face enormous challenges in overcoming their addiction. These challenges include physical, social, and economic barriers to seeking treatment. They are pervasive and exist even as the women seek treatment. Further, the challenges encompass the more rapid progression of the women's disease from use to abuse and dependence as compared to their male counterparts.[10] Pregnant and parenting women encounter the same minefield of issues as non-pregnant and childless women, but must also face a heightened level of risk in terms of physical and sexual abuse,[11] extensive social stigma,[12] and of course the complexity of balancing

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9. *Id.*

10. Carlos A. Hernandez-Avila et al., *Opioid-, Cannabis- and Alcohol-dependent Women Show More Rapid Progression to Substance Abuse Treatment*, 74 DRUG AND ALCOHOL DEPENDENCE 265, 265 (2004); Patrick P. Johnson, *Telescoping of Drinking-Related Behaviors: Gender, Racial/Ethnic, and Age Comparisons*, 40 SUBSTANCE USE AND MISUSE 1139, 1144, 1146 (2005).

11. Sandra L. Martin et al., *Violence and Substance Use Among North Carolina Pregnant Women*, 86 AM. J. OF PUB. HEALTH 991, 991 (1996); Howell et al, *supra* note 7, at 198.

12. Shelly F. Greenfield et al., *Substance Abuse Treatment Entry, Retention, and Outcome in Women: A Review of the Literature*, 86 DRUG & ALCOHOL DEPENDENCE 1, 5 (2007), *citing* Christine Grella et al.,

their own often failing health, the health of their unborn child, and the well-being of their existing children. More specifically, the affected women face personal barriers to treatment such as fear of reprisal from significant others and family members,[13] fear of not being able to care for children,[14] a fear of losing custody of their children,[15] stigma associated both with using as a woman and, more particularly as a pregnant woman,[16] fear about confidentiality,[17] and finally, a fear of making life changes.[18] In addition, research suggests that women who struggle with substance disorders are more likely to come from "drug-abusing and disorganized families"[19] and they are often isolated from healthy support systems.[20] Also complicating this sense of isolation is the fear that their partners may become abusive either because of the women's use or because the partners do not want the women to expose their own use by seeking treatment.[21] Evidence also suggests that women experience a greater rate of co-occurring medical, psychiatric and psychosocial problems as compared with their male counterparts.[22] These factors serve as barriers to substance abuse services for pregnant and parenting women. Other barriers include intrapersonal issues such as guilt, shame, a lack of knowledge about addiction,[23] and a lack of knowledge regarding how to access health care.

Characteristics of Women-Only and Mixed-Gender Drug Abuse Treatment Programs, 17 J. SUBSTANCE ABUSE TREATMENT 37 (1999).

13. NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS (NASADAD) GUIDANCE TO STATES: TREATMENT STANDARDS FOR WOMEN WITH SUBSTANCE USE DISORDERS 7 (2008), http://www.dsf.health.state.pa.us/health/lib/health/bdap/GuidancetoStates.pdf [hereinafter GUIDANCE TO STATES].

14. *Id.*

15. Cynthia I. Campbell & Jeffrey A. Alexander, *Availability of Services for Women in Outpatient Substance Abuse Treatment: 1995-2000*, 33 J. BEHAV. HEALTH SERVS. & RES. 1, 2 (2006); GUIDANCE TO STATES, *supra* note 13, at 7; Thomas M. Brady & Olivia Silber Ashley eds., *Women in Substance Abuse Treatment: Results from the Alcohol and Drug Services Study*, OFFICE OF APPLIED SCIENCES, U.S. DEP'T OF HEALTH & HUMAN SERVS., SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN. 12 (2005), www.oas.samhsa.gov/womenTX/womenTX.pdf.

16. Campbell & Alexander, *supra* note 15, at 2; Janet Hankin et al., *Pregnant, Alcohol-Abusing Women*, 24 ALCOHOLISM: CLINICAL AND EXPERIMENTAL RES. 1276, 1279 (2000). *See* Howell et al., *supra* note 7, at 197 ("[A] substantial proportion of drug-abusing women (46.5%) in one study felt that pregnant chemically dependent women should go to jail.").

17. GUIDANCE TO STATES, *supra* note 13, at 7.

18. *Id.*

19. Jeanne C. Marsh et al., *Increasing Access and Providing Social Services to Improve Drug Abuse Treatment for Women With Children*, 95 ADDICTION 1237, 1238 (2000).

20. *Id. See also* Greenfield et al., *supra* note 12, at 15.

21. Marilyn Daley et al., *Substance Abuse Treatment for Pregnant Women: A Window of Opportunity?*, 23 ADDICTIVE BEHAVS. 239, 247 (1998); Martin et al., *supra* note 11, at 993.

22. William H. Miller Jr. & Mark C. Hyatt, *Perinatal Substance Abuse*, 18 AM. J. DRUG ALCOHOL ABUSE 247; Marsh et al., *supra* note 19, at 1238; P.M. Quinby & A.V. Graham, *Substance Abuse Among Women*, 20 PRIMARY CARE 131, 132, 134 (1993) (finding that when compared to men, women may be at an increased risk for physical complications because of the difference in alcohol metabolism. For example, after drinking the same amount of alcohol it has been found that women have higher blood alcohol levels. Authors also found that women have more health-associated problems than their male counterparts).

23. *See* SUBSTANCE USE TREATMENT AMONG WOMEN OF CHILDREARING AGE, THE NSDUH (NATIONAL SURVEY ON DRUG USE AND HEALTH) REPORT 2 (2007), *available at* http://www.oas.samhsa.gov [hereinafter NSHUH REPORT] (finding that in 2006, 84.2% of the 7.4 million

2. Treatment Components

In addition to overcoming the personal barriers outlined above, a treatment program must provide treatment for the disease of addiction. There are a range of service modalities available for pregnant and parenting women including detox, outpatient, intensive outpatient, and residential treatment programs.[24] Within these settings there are a wide array of interventions including psychosocial interventions, medication assisted treatment, and wrap around services, which include parenting/family skills development, prenatal care, perinatal care, domestic violence services, and childcare services.[25] The question then is, out of all the possible components, which are most effective for pregnant and parenting women.

With regard to the most effective service modalities, the existing research indicates that while more research is needed, enhanced outpatient may be just as effective as residential treatment for most women.[26] Thus, although residential treatment may be required for severely dependant women, for other women enhanced outpatient "may be preferable and more cost effective."[27] However, as between enhanced outpatient and conventional outpatient, the enhanced outpatient treatment was found by at least one study to be more effective than conventional outpatient.[28] The enhanced portion for some of these programs include the following: intensive participation, i.e., four to five days per week; urine tests; individual counseling; family education; family therapy; couples counseling; relapse prevention and twelve-step groups. [29] Others include "parenting training, education about drug use, and personal development activities."[30]

In addition to choosing between modalities, choices have to be made as to the proper treatment methods. The use of opioids by pregnant women presents a special case because research has found that for pregnant women who are dependent upon opioids, most cannot remain drug-free throughout pregnancy.[31] Thus, to avoid the fetal distress caused by a cycle of intoxication

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women who needed treatment for a substance abuse disorder neither received treatment, nor perceived a need for it).

24. Christine Grella & Lisa Greenwell, *Substance Abuse Treatment for Women: Changes in the Settings Where Women Received Treatment and Types of Services Provided, 1987-1988*, 31 J. BEHAV. HEALTH SERVS & RES. 367, 368–69 (2004).

25. *Id.*

26. Howell et al., *supra* note 7, at 216; Barbara C. Wallace, *Chemical Dependency Treatment for the Pregnant Crack Addict: Beyond the Criminal-Sanctions Perspective*, 5 PSYCHOL. ADDICTIVE BEHAV. 25 (1991).

27. Wallace, *supra* note 26, at 25.

28. Howell et al., *supra* note 7, at 215.

29. *Id.*

30. *Id.*

31. Bernadette Winklbaur et al., *Treating Pregnant Women Dependent on Opioids is not the Same as Treating Pregnancy and Opioid Dependence: a Knowledge Synthesis for Better Treatment for Women and Neonates*, 103 ADDICTION 1429, 1430 (2008).

and abstinence,[32] maintenance therapy with methadone or buprenorphine is the recommended treatment approach.[33]

A review of the critical, although somewhat scant, literature on the other key components for successful treatment of pregnant and parenting women finds a range of interventions. Within this range, however, it is generally recognized that certain components lead to better outcomes. Several of the components are related to the mandate that a program be sensitive to the unique needs of women. Thus, a women-only program is most often preferred because, overall, (1) women in women-only drug abuse treatment programs were more than twice as likely to complete treatment as women in mixed-gender programs, and (2) pregnant women in women-only drug abuse treatment programs averaged more days in treatment than did those in mixed-gender programs: 87.4 days vs. 74 days.[34] Successful treatment services for pregnant women must also be family-centered, comprehensive, and staffed by an interdisciplinary team of professionals who interact with the women in a nonjudgmental, nurturing way.[35] Research also confirms that a confrontational approach does not work well with women.[36] Further, providers must be sensitive to individual cultures, must focus on the importance of communication and how language is used, and must address mental health problems.[37]

Research also indicates that increased attendance in treatment is critical to treatment success.[38] Thus, any mechanism that can improve length of stay is critical. In this regard, of overarching and critical import is the research that indicates that programs that allow the children to stay with their mother in residential treatment are more successful in retaining clients in care.[39] Similarly, for outpatient services the comprehensive review of the literature, as well as other investigations, have found that treatment for mothers is often more effective when coordinated with child care and transportation services,[40] as well as prenatal care, mental health services, and support services.[41] Further, other

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32. *Id*.

33. Bernadette Winklbaur et al., *Opioid Dependence and Pregnancy*, 21 CURRENT OPINION IN PSYCHIATRY 255, 255 (2008).

34. Brady & Ashley, *supra* note 15, at 34; Grella & Greenwell, *supra* note 24, at 368.

35. Howell et al., *supra* note 7, at 209, 215. *See* Wallace *supra* note 26, at 25 (necessary services include "support groups, comprehensive prenatal care, pediatric care, obstetric services, developmental and emotional assessment of the infant, provision of clinical interventions for infants, medical and psychological treatment for mothers, an option for comprehensive residential drug treatment (job training, education, housing assistance), and regular contact between biological mothers and infants placed in foster care").

36. Howell et al., *supra* note 7, at 209.

37. *Id.* at 199, 209, 213, 216.

38. Greenfield et al., *supra* note 12, at 6; Sharon M. Mullins et al., *The Impact of Motivational Interviewing on Substance Abuse Treatment Retention: A Randomized Control Trial of Women Involved with Child Welfare,* 27 J. SUBSTANCE ABUSE TREATMENT 51, 56 (2000).

39. Steverson, *Prenatal Drug Exposure*, *supra* note 1, at 51–52; Brady & Ashley, *supra* note 15, at 37; Howell et al., *supra* note 7, at 215. *See* Greenfield et al., *supra* note 12, at 9 (within residential programs, "policies allowing children to accompany their mothers in treatment have been demonstrated to have a positive effect on treatment retention").

40. Marsh et al., *supra* note 19, at 1238; Greenfield et al., *supra* note 12, at 14 ("[C]hildcare is essential for recovery in women with children.").

41. Brady & Ashley, *supra* note 15, at 39.

research on treatment strategies for pregnant and parenting women indicates that contingency management strategies are effective in improving retention rates and reducing illicit drug use of pregnant women in drug treatment.[42] Finally, motivational interviewing, educational videos, home visits and treatment as usual were all associated with greater engagement and retention.[43]

Regarding specifics, an excellent resource on the type of programs needed for pregnant and parenting women is an article by Barbara Wallace.[44] In this article, Wallace draws on her experience of working with pregnant crack cocaine smokers in an inpatient detoxification unit and a residential therapeutic community setting to present detailed recommendations that can be incorporated into existing treatment programs.[45] While a reader who wants detailed information is advised to read the article, a few highlights will be discussed. First, Wallace stresses that many addicts have a defensive stance characterized by arrogance and aloofness. Given that the stance generally is put in place to protect against feelings of pain, loss, shame, and guilt, the clinician must be careful to avoid reacting negatively to this stance, as such a reaction may cause the woman to close up, which will impede treatment.[46] Secondly, she cautions that there is no one-size-fits-all modality for pregnant substance abusers. Rather, clinicians must assess the client's needs and match that client to the proper modality.[47] Finally, for whatever modality is chosen, individual counseling is necessary to address the consequences of trauma such as child abuse, sexual abuse, domestic violence, rape and other types of violence.[48]

A final component of an effective treatment program is the provision of recovery services. As has been discussed elsewhere, such services are crucial to prevent addiction relapses.[49] As the Oregon Governor's Council stated in its 2009–2011 report, "[t]he recovery phase of treatment addresses [the] supports an individual needs to sustain sobriety: mentoring, housing, employment assistance, transportation, continued education, or socialization. Stable housing is an essential element for anyone recovering from alcohol or other drug addiction."[50]

B. Unmet Need

Many studies demonstrate that, compared with the number of women with substance use disorders, there are relatively low numbers of women in

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42. Winklbaur et al., *supra* note 31, at 1435.
43. *Id.*
44. Wallace, *supra* note 26, at 23.
45. *Id.*
46. *Id.* at 29–30.
47. *Id.* at 31.
48. *Id.*
49. Steverson, *Prenatal Drug Exposure*, *supra* note 1, at 51.
50. THE GOVERNOR'S COUNCIL ON ALCOHOL AND DRUG ABUSE PROGRAMS, THE DOMINO EFFECT II: A BUSINESS PLAN TO CONTINUE RE-BUILDING SUBSTANCE ABUSE PREVENTION, TREATMENT AND RECOVERY SERVICES 37 (2009), http://egov.oregon.gov/DHS/addiction/publications/domino-effect-v10.pdf [hereinafter OREGON GOVERNOR'S COUNCIL REPORT].

substance abuse treatment programs.[51] The reasons for this disparity are varied, but they center on the numerous barriers that women face when they seek treatment. Some barriers are systemic and some are personal.[52] The personal barriers that women face were outlined above.[53] However, because this paper is focused on possible legislative means for expanding access to treatment services, it will primarily discuss the systemic barriers that pregnant and parenting women face. Such barriers are more amenable to legislative solutions than personal barriers. As discussed above, however, in creating effective treatment programs, the state needs to encourage the providers to be aware of and work to overcome the personal barriers.[54]

The systemic barriers that women face include insufficient programs with women or pregnant women-focused services, lack of money or insurance, unemployment, and homelessness.[55] In conjunction with these systematic and social barriers, associated logistical issues such as limited transportation, poor literacy, and a lack of child care also prevent women from seeking substance abuse treatment services. [56] In fact, some commentators contend that "little access to child care services is one of the most significant and frequently cited barriers among women who seek treatment."[57]

1. Dearth of Programs

Most commentators agree that there is an overall paucity of substance abuse treatment, reproductive, and social services tailored for women and their unique needs and lives.[58] However, very little detailed information is given as to what currently exists and what is needed. This section is designed to outline the information that currently exists on this topic. The section will examine this question in a general sense with regard to the national scene and then will focus on specific examples from Washington, California, and Oregon.

The evidence demonstrates that the past thirty years have seen a marked increase in the number of treatment programs available to pregnant and mothering women. Prior to the 1970s, there were very few treatment centers for

51. Greenfield et al, *supra* note12, at 3, 15; Deborah A. Dawson, *Gender Differences in the Probability of Alcohol Treatment*, J. SUBSTANCE ABUSE TREATMENT 211, 221–22 (1996); Constance Weisner & Laura Schmidt, *Gender Disparities in Treatment for Alcohol Problems*, 268 J. AM. MEDICAL ASSOC. 1872, 1874. *See* Marsh et al., *supra* note 19, at 1238 (a 1998 study "estimated that 67% of parents involved in the child welfare system needed treatment for the abuse of drugs and alcohol, but services were available—either directly or through contracted services—to only 31%.").

52. Greenfield et al., *supra* note 12, at 16; GUIDANCE TO STATES, *supra* note 13.

53. See *supra*, notes 10–23 and accompanying text.

54. See *supra*, notes 10–23 and accompanying text.

55. Campbell & Alexander, *supra* note 15, at 2; Michelle Tuten et al., *Comparing Homeless and Domiciled Pregnant Substance Dependent Women on Psychosocial Characteristics and Treatment Outcomes*, 69 DRUG & ALCOHOL DEPENDENCE 95, 98 (2003). *See also* GUIDANCE TO STATES, *supra* note 13; Brady & Ashley, *supra* note 15, at 9 (discussing the economic circumstances of drug-abusing women).

56. Marsh et al., *supra* note 19, at 1237; GUIDANCE TO STATES, *supra* note 13. *See also* Brady & Ashley, *supra* note 15, at 9 (discussing the economic circumstances of drug-abusing women).

57. Brady & Ashley, *supra* note 15, at 8.

58. Greenfield et al., *supra* note 12, at 3–4.

women, let alone pregnant women.[59] In the 1970s the National Institute on Drug Abuse (NIDA) began to sponsor and develop substance abuse treatment programs for women.[60] However, in the late 1970s and early 1980s these funds began to shrink such that there was a shortage of treatment programs for women and specifically for mothers and pregnant women.[61] For example, a 1979 study found only twenty-five programs nationally for women.[62] In the late 1980s, funding became available for the creation of treatment programs for pregnant women, due largely to the perceived crack/cocaine epidemic and the effect of exposure to such drugs on a developing fetus.[63] A 1994 study found that, out of 294 facilities in five cities (including New York), 80% accepted pregnant women.[64] Unfortunately, most did not accept women on Medicaid or arrange for child care.[65] As of 1996–97, out of 2,395 treatment facilities nationwide, 562 offered special programs for pregnant women.[66]

Currently, as of 2007, out of 13,648 mental health and substance abuse facilities nationwide, 1,926 had programs specifically designed for pregnant and postpartum women.[67] This number represents 14.1% of the total treatment facilities in existence at the time.[68] However, there is agreement that there is a need for more treatment centers for parents.[69] There also seems to be agreement that more treatment centers for pregnant and parenting women are needed. Due to the inadequacy of data collection, however, it is difficult to put in place a truly reliable figure to flesh out the meaning of the term "more" because we do not know exactly how many women are served by these programs, or exactly how many more need to be served. Yet, the available data does allow us to provide some estimates. These estimates show that, even if we only require treatment services for binge/heavy drinkers and users of illicit drugs, we do not have a sufficient number of facilities. Thus, as of 2007, at any one time there

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59. Howell et al., *supra* note 7, at 195.

60. *Id*. *See also* Brady & Ashley, *supra* note 15, at 30 for a discussion of these early programs.

61. Howell et al., *supra* note 7, at 195.

62. *Id*. at 196.

63. *Id*.

64. *Id*.

65. *Id*.

66. Brady & Ashley, *supra* note 15, at 47 (Figures were pulled from the Alcohol and Drug Services Study (ADSS) of the SAMHSA Office of Applied Sciences).

67. OFFICE OF APPLIED STUDIES, U.S. DEP'T OF HEALTH AND HUMAN SERVS., NATIONAL SURVEY OF SUBSTANCE ABUSE TREATMENT SERVICES (N-SSATS) table 4.11a, 56 (2007), http://www.oas.samhsa.gov/dasis.htm#nssats2 [hereinafter NATIONAL SURVEY OF SUBSTANCE ABUSE TREATMENT SERVICES].

68. *Id*. (Out of 13,648 treatment facilities, 1,926 served pregnant and parenting women).

69. *See* PRESENTATION ON THE CHILD AND FAMILY SERVICES REVIEW BY THE NATIONAL CENTER OF SUBSTANCE ABUSE AND CHILD WELFARE AND THE NATIONAL ASSOCIATION OF STATE ALCOHOL DRUG ABUSE DIRECTORS 28 (2007) (in reviewing the 2001–03 reports from the states on the federally mandated review of their child and family services, it was found that substance abuse services for substance abusing parents were not represented in the array of available services.) *See also Foster Care, States Focusing on Finding Permanent Homes for Children, but Long-Standing Barriers Remain*: *Hearing Before the Subcomm. on Human Resources of the H. Comm. on Ways and Means*, 110th Cong. (2007) (statement of Cornelia Ashby, Director, Education, Workforce, and Income Security Issues, United States General Accounting Office) ("33 states reported in our survey that the lack of substance abuse treatment programs is a barrier to achieving permanency for children.").

were between 149,604 and 255,164 or more pregnant women in their second or third trimesters who were heavy drinkers or users of illicit drugs.[70] Even if we assume that all of the beds in the 1,926 treatment facilities are reserved for pregnant or postpartum women (an extremely unlikely fact), these facilities could only serve 131,315 people on any given day.[71] Of course, if we add in pregnant women in their first trimester, the gap between need and services grows larger.

This number of available facilities begins to grow smaller if we take into account the fact that, of the 1,926 mental health and substance abuse treatment facilities identified in the 2007 National Survey of Substance Abuse Treatment Services (N-SSATS), only 1,363 of these have substance abuse treatment as their primary focus.[72] The number shrinks further if we search for facilities that offer some of the services identified as necessary for pregnant and parenting women. For example, childcare is a necessary component for the majority of women seeking treatment, however, out of the 13,648 mental health and substance abuse treatment facilities in existence in 2007,[73] for those whose primary focus is substance abuse, only 760 provide childcare and only 410 have residential beds for clients' children.[74] Further, the data indicates that the number of treatment facilities serving pregnant women is smaller now than in 2000; however, the number of women needing treatment is growing.[75]

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70. The estimate of 149,604 is calculated as follows: The 2006 census estimates that 4.13 million women gave birth during that year. U.S. CENSUS BUREAU, FERTILITY OF AMERICAN WOMEN: 2006, *available at* http://www.census.gov/population/www/socdemo/fertility.html. If we assume that these women gave birth about equally each month, then on average, 344,000 women gave birth each month. If we assume that the women were pregnant an average of 8 months prior to the birth, then at any one time there were 2.8 million women pregnant (344,000 x 8 = 2.75 million). Two-thirds of those, or 1.82 million, are in their second or third trimester. Out of this 1.82 million pregnant women we find that, in one month, 5.2% used illicit drugs and 4.4% were binge (3.7%) or heavy drinkers (.7%). OFFICE OF APPLIED STUDIES, U.S. DEP'T OF HEALTH AND HUMAN SERVS., RESULTS FROM THE 2007 NATIONAL SURVEY ON DRUG USE AND HEALTH: NATIONAL FINDINGS, *available at* http://www.oas.samhsa.gov/nsduhLatest.htm. 31.3% of these heavy/binge drinkers are also illicit drug-using women. That means that the total percentage of heavy/binge drinkers and/or illicit drug-using pregnant women is 8.22% [(68.7% of 4.4% = 3.02%) + 5.2% = 8.22%]. 8.22% of 1.82 million = 149,604.

The estimate of 255,164 is calculated in the same manner as above, however, the percentage of illicit drug-using pregnant women is 11% rather than 5.2%. This higher percentage is based upon a Maternal Life Study that showed that 11% of infants screened had a meconium toxicology screen that was positive for cocaine or opioids. Brady & Ashley, *supra* note 15. Thus, 11% (drugs) + 3.02% (alcohol) = 14.02% of 1.82 million = 255,164.

71. An analysis of the complete data set in N-SSATS demonstrates that the mean number of beds in a facility is 68.18. If that number is multiplied by the 1,926 facilities that have programs for pregnant and postpartum women, we find a maximum number of 131,315 beds available for these women. NATIONAL SURVEY OF SUBSTANCE ABUSE TREATMENT SERVICES, *supra* note 67.

72. NATIONAL SURVEY OF SUBSTANCE ABUSE TREATMENT Services, *supra* note 67, at 56.

73. *Id.* at 51–52.

74. *Id.* at 53.

75. In the year 2000, there were 2,761 treatment facilities serving pregnant and parenting women. That number subsequently decreased as follows: 2,573 in 2002; 1,851 in 2003; 1888 in 2004; 1880 in 2005; 1951 in 2006; 1926 in 2007. NATIONAL SURVEY OF SUBSTANCE ABUSE TREATMENT Services, *supra* note 67.

With regard to the need in individual states, in Oregon the data indicates that there is more need for services than there are resources to meet the needs of parents.[76] For substance abusers in general, as of 2006, 258,045 Oregonians experienced substance abuse or dependence problems.[77] However, only a little less than 66,000 persons accessed publicly funded treatment.[78] As the following statistics demonstrate, for substance-abusing parents, their unmet needs are growing rather than decreasing. In 2000, 27.6% of parents of foster care entrants had unmet needs.[79] That percentage remained relatively flat until 2003 when it jumped to 37.3% of unmet needs and 2005 when it jumped to 46.7% of unmet needs.[80] Further, a 2005 mental health survey found that more than 5,700 people in Oregon were in need of affordable or service enriched housing and that an estimated 2,342 persons needed recovery housing that assists with sustaining sobriety.[81]

The 2004 Child and Family Services Report (CFSR) for Washington found that, similar to Oregon, Washington did not achieve substantial conformity with its systemic factor of service array.[82] This was due in part, to "critical gaps in its service array, particularly in the areas of mental health services and substance abuse treatment." [83] An example of this gap was the difficulty that parents had in accessing substance abuse treatment services.[84] In contrast, neither California's 2003 CFSR, nor its 2008 CFSR reported a general lack of substance abuse treatment services for parents.[85] However, California's 2003 CFSR did

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76. ADDICTIONS AND MENTAL HEALTH DIVISION (AMH) UPDATE: PERFORMANCE MEASURES FOR TREATING SUBSTANCE ABUSE, (2007), http://egov.oregon.gov/DHS/addiction/publications/fact-sheets/fs-pm4treat-sub-abuse-dhs.pdf [hereinafter OREGON PERFORMANCE MEASURES] (providing data from 2000 to 2005 of the percentage of foster care entrants removed because of parental substance abuse and whose parents need, but did not receive treatment). *See also* CHILDREN'S BUREAU, U.S. DEP'T OF HEALTH & HUMAN SERVS., OREGON CHILD AND FAMILY SERVICES REVIEW (CFSR) FINAL REPORT 3–4 (2008), http://www.oregon.gov/DHS/children/cfsr/2007-report.pdf (Oregon had a low performance with regard to child outcomes which may have been due in part, to a lack of key services and delays in services, particularly with regard to substance abuse treatment); OREGON GOVERNOR'S COUNCIL REPORT, *supra* note 50, at 33. ("Lack of access for substance abuse treatment services continues to be a major hindrance for improving the health of Oregonians.).

77. OREGON GOVERNOR'S COUNCIL REPORT, *supra* note 50, at 33.

78. *Id.* ("Despite a small increase in treatment funding in the 2007 Legislature and the passing of parity legislation for group insurance-covered health care underwritten in Oregon, 258,049 Oregonians either abuse or are dependent on alcohol or other drugs" (citing NATIONAL SURVEY OF DRUG USE AND HEALTH (2006–07), PORTLAND STATE CENTER FOR POPULATION STUDIES). Of that number, "[a]pproximately 64,532 people identified by the department of Addictions and Mental Health Data System (CPMS) received treatment using public funds, with another 1,220 treated each year in the prison system.")).

79. OREGON PERFORMANCE MEASURES, *supra* note 76, at 1.

80. *Id*.

81. OREGON GOVERNOR'S COUNCIL REPORT, *supra* note 50, at 38.

82. CHILDREN'S BUREAU, U.S. DEP'T OF HEALTH & HUMAN SERVS., WASHINGTON CHILD AND FAMILY SERVICES REVIEW (CFSR) FINAL REPORT 9 (2004).

83. *Id.*

84. *Id.* at 63.

85. *See* CHILDREN'S BUREAU, U.S. DEP'T OF HEALTH & HUMAN SERVS., CALIFORNIA CHILD AND FAMILY SERVICES REVIEW (CFSR) FINAL REPORT (2003) (the report found that drug treatment services are widely available, but waiting lists were reported in some areas); CHILDREN'S BUREAU, U.S. DEP'T OF HEALTH & HUMAN SERVS., CALIFORNIA CHILD AND FAMILY SERVICES REVIEW (CFSR) FINAL REPORT

report that there existed a service gap of substance abuse treatment facilities where parents can bring their young children.[86]

2. Lack of Adequate Funding

As will be demonstrated, part of the problem of access to appropriate treatment services for pregnant and parenting women is a lack of sufficient funding.[87] This funding problem has at least two facets. First, there is a lack of funding to create the necessary programs and second, there is a lack of funding to enable individual women to pay for those treatment services that do exist.

a. Sources of Funding

In order to understand the role of funding in contributing to unmet need, one must have a basic understanding of how substance abuse treatment is funded. In outlining the funding streams, this article will focus on publicly funded treatment programs. This is done for three reasons. First, those persons who utilize privately funded programs usually have sufficient personal resources to access the programs without difficulty. Second, unlike health care that is largely paid for by private insurance, substance abuse treatment is "financed largely by the public sector."[88] Third, the programs for pregnant and mothering substance abusers are generally located within publicly funded programs.[89]

The public funding for drug treatment programs comes from three basic sources: the federal government (excluding Medicaid), Medicaid, and state and local governments (excluding Medicaid).[90] Starting with the federal government, the largest portion of this funding is provided by the Federal Substance Abuse Prevention and Treatment ("SAPT") block grant program.

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9 (2008) (Although California was not in substantial conformity with the systemic factor of service array, this was not due to a lack of substance abuse treatment services for parents).

86. 2003 CALIFORNIA CFSR, *supra* note 85, at 83.

87. Kimberly Dennis et al., *Funding Family-Centered Treatment for Women With Substance Use Disorders*, OFFICE OF PROGRAM ANALYSIS AND COORDINATION, CENTER FOR SUBSTANCE ABUSE TREATMENT, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA) 1 (2008), http://www.samhsa.gov.

88. Alexander Cowell et al., *Impact of Federal Substance Abuse Block Grants on State Substance Abuse Spending: Literature and Data Review*, 6 J. MENTAL HEALTH POL'Y ECON.,173, 174 (2003). *See also* TAMI L. MARK ET AL., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., NATIONAL EXPENDITURES FOR MENTAL HEALTH SERVICES AND SUBSTANCE ABUSE TREATMENT 1993–2003, 38 (2007), http://www.samhsa.gov/spendingestimates/SAMHSAFINAL9303.pdf.

89. Telephone interview with Richard Harris, Interim Director for Oregon State's Division of Addictions and Mental Health (AMH) (January 2009). Among other duties, the director of AMH is responsible for putting together implementation procedures for the federal SAPT block grants. In addition, using the SAMHSA database to research the number of private programs in Oregon that had pregnant and/or parenting programs for women, the authors located only four programs—Beyond Addictions, Ontrack, Inc., Eastern Oregon Alcoholism Foundation, and Addictions and Family Counseling. *See* http://www.samhsa.gov.

90. For a detailed discussion of the history of and current state of federal funding for substance abuse treatment see E. Michelle Tupper, *Children Lost in the Drug War: A Call for Drug Policy Reform to Address the Comprehensive Needs of Family*, 12 GEO. J. ON POVERTY L. & POL'Y 325, 328–33 (2005).

This program is administered by the Department of Health and Human Services and managed by the Substance Abuse and Mental Health Services Administration ("SAMHSA"). [91] These grants make up approximately 40% of the federal public funding for substance abuse treatment in general[92] and approximately 8% of the total public spending.[93] In deciding how to use SAPT funds, the states are granted broad discretion as long as they abide by two conditions: (1) states must file an annual report on their use of the funds, and (2) states must maintain the efforts in this area that existed at the time of the state funding. [94] All of the states that have received SAPT funds have used these funds in the past [95] and continue to use SAPT funds to develop and expand treatment programs.[96]

To obtain SAPT funding, states complete an annual application detailing program accomplishments to date and enclosing a plan for the forthcoming year. [97] The amount of funding provided to qualifying states in FY2008 was approximately $1.76B[98] For the current fiscal year, the National Association of State Alcohol and Drug Abuse Directors (NASADAD) is lobbying for at least a $100M increase in SAPT block grant funding as part of the Obama stimulus package.[99]

Although the percentage of SAPT grant expenditures on a national level is fairly low in comparison to other funding sources, that percentage varies considerably from state to state.[100] For example, in our sample states of California, Oregon and Washington, in California and Oregon the SAPT funding constituted the largest percentage of their public expenditures.[101] Thus, in

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91. Cowell et al., *supra* note 88, at 173 (explaining the program administration).

92. MARK ET AL., *supra* note 88, at 39 and Appendix A (finding that in 2003 total federal expenditure on substance abuse was $3.066 billion and the SAPT expenditure was $1.2 billion, thus, the SAPT expenditure was approximately 40% of the total federal expenditure).

93. *Id*. at v.

94. Cowell et al., *supra* note 88, at 173.

95. *See infra* notes 170–180 and accompanying text (discussing the residential treatment programs developed with the use of SAPT grants).

96. See the state summaries for FY 2008–09 outlining the various programs in all of the states that are funded through the Center for Substance Abuse Treatment (CSAT), which is the treatment arm of SAMHSA. http://www.samhsa.gov/statesummaries/index.aspx.

97. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., FINAL UNIFORM APPLICATION, SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT, OMB NO. 0930-0080.

98. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., SAMHSA GRANT AWARDS BY STATE—STATE SUMMARIES FY 2008/2009, *available at* http://www.samhsa.gov/statesummaries/index.aspx [hereinafter STATE SUMMARIES] (in FY2008 the block grants had an enacted budget authority of $1.76B).

99. *See, e.g.*, Letter from Robert Morrison, NASADAD Director of Public Policy, to NASADAD/NPN/NTN Members, *Re: D.C. Update: Special FY 2009 Senate Committee Appropriations Update* (June 26, 2008).

100. *Id*.

101. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T. OF HEALTH & HUMAN SERV., CALIFORNIA PROGRAM DESCRIPTION, http://www.nationaloutcomemeasures.samhsa.gov/PDF/StateProfiles/2008/ca.pdf (In California in 2006, the public expenditures for substance abuse prevention and treatment were as follows: 42% SAPT; 33% State funds (excluding Medicaid); 21% Medicaid; 4% other federal funds); SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T.

California in FY 2008–09, California received $249.93M in SAPT block grant money.[102] This represents 42% of California's total public expenditures for substance abuse prevention and treatment, compared to 33% from state funding.[103] Similarly, but on a reduced scale, in FY 2008–09, Oregon received $16.2M in SAPT block grant money.[104] This represents 38% of Oregon's total public substance abuse treatment and prevention expenditures, compared to 30% from state funding.[105] In Washington, however, both state and local funding and Medicaid funding constituted a higher percentage of expenditures than SAPT.[106] Thus, in Washington for FY 2008–09, the state received $34.86M in SAPT block grant money.[107] This represents 23% of Washington's total public expenditures on substance abuse prevention and treatment, compared to 45% from state funding.[108]

In addition to SAPT, there are a number of other quite diverse federal funding sources. These sources include, among others, SAMHSA supplemental grants,[109] the Department of Defense, the Department of Veterans Affairs,[110] Temporary Assistance for Needy Families (TANF),[111] and the State Children's

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OF HEALTH & HUMAN SERVS., OREGON PROGRAM DESCRIPTION, http://www.nationaloutcomemeasures.samhsa.gov/PDF/StateProfiles/2008/or.pdf (In Oregon in 2006, the public expenditures for substance abuse prevention and treatment were as follows: 38% SAPT; 30% State funds (excluding Medicaid); 23% Medicaid; 9% other federal funds).

102. STATE SUMMARIES, *supra* note 98.

103. CALIFORNIA PROGRAM DESCRIPTION, *supra* note 101.

104. STATE SUMMARIES, *supra* note 98.

105. OREGON PROGRAM DESCRIPTION, *supra* note 101.

106. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T. OF HEALTH & HUMAN SERVS.WASHINGTON PROGRAM DESCRIPTION, http://www.nationaloutcomemeasures.samsha.gov/PDF/StateProfiles/2008/wa.pdf (In Washington in 2006, the public expenditures for substance abuse prevention and treatment were as follows: 45% State funds; 25% Medicaid; 23% SAPT, and 7% other federal funds).

107. STATE SUMMARIES, *supra* note 98.

108. WASHINGTON PROGRAM DESCRIPTION, *supra* note 106.

109. *See* CSAT DIRECTOR'S 2008 REPORT TO THE NATIONAL ADVISORY COUNCIL 33, *available at* http://www.nac.samhsa.gov/CSATcouncil/Docs/March08/CSATdirectorReport0308.pdf (discussing SAMHSA supplemental grants given in FY 2007). California received $12.72M from SAMHSA for substance abuse prevention and $33.67M for substance abuse treatment. STATE SUMMARIES, *supra* note 98. Oregon received $3.8M from SAMHSA for substance abuse prevention and $5.0M for substance abuse treatment. *Id*. Washington received $5.62M from SAMHSA for substance abuse prevention and $6.84M for substance abuse treatment. *Id*.

110. MARK ET AL., *supra* note 88, at 39.

111. Temporary Assistance to Needy Families (TANF) is a bureau within Health and Human Services under the program of the same name. http://www.acf.hhs.gov/programs/ofa/tanf/about.html. The TANF Bureau has primary responsibility for Titles IV-A and XVI of the Social Security Act, focusing primarily on distribution and monitoring of a state block grant. *Id.* The grant has four purposes: (1) assisting needy families so that children can be cared for in their own homes; (2) reducing the dependency of needy parents by promoting job preparation, work and marriage; (3) preventing out-of-wedlock pregnancies; and (4) encouraging the formation and maintenance of two-parent families. *Id.* Each state then has its own TANF program. In California, this program is CALWORKS; in Oregon, it is called JOBS; and in Washington, it is called WorkFirst. http://www.acf.hhs.gov/programs/ofa/states/tnfnames.htm. These programs are the welfare programs of today, with an increased emphasis on migration to work. There is a minor component that includes referrals for family services, including substance abuse.

Health Insurance Plan (SCHIP).[112] In addition to public funding for the creation of substance abuse treatment programs, there is funding that allows substance abusers to directly access treatment services. The largest source of funding for this purpose is Medicaid.[113] Medicaid is a public health insurance program for certain indigent persons, including women with children, that is funded through both federal and state monies.[114] Under the program, a state will reimburse the providers of health services for any services rendered to Medicaid-eligible persons.[115] The federal government will then reimburse the state for at least 50% of its expenditures.[116] It is important to note that a state is not required to fund behavioral health services such as substance abuse treatment.[117]

The third source of public funding for substance abuse treatment is state and local government (excluding Medicaid). In contrast to states like Oregon and California, state and local funding has for the majority of states become the largest source of funding for substance abuse treatment.[118] In fact, a 2007 review of national expenditures for mental health and substance abuse found that 52% of public funding came from state and local government funding.[119] Compare this to 23% from Medicaid, 19% from federal government spending (excluding Medicaid, but including block grants), and 6% from Medicare.[120] These state and local funds come from a variety of sources including state and county

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112. ANNA SCANLON, NATIONAL CONFERENCE OF STATE LEGISLATURES, STATE SPENDING ON SUBSTANCE ABUSE TREATMENT (2002), http://www.ncsl.org/programs/health/forum/pmsas.htm.

113. Cowell et al., *supra* note 88, at 177.

114. UNITED STATES GENERAL ACCOUNTING OFFICE, REPORT TO CONGRESSIONAL REQUESTERS, SUBSTANCE ABUSE TREATMENT, MEDICAID ALLOWS SOME SERVICES BUT GENERALLY LIMITS COVERAGE, GAO/HRD-91-92 2 (1991), *available at* http://www.gao.gov/products/HRD-91-92 [hereinafter GAO REPORT] (Medicaid is authorized under title XIX of the Social Security Act). *See* Joanmarie Ilaria Davoli, *No Room at the Inn: How the Federal Medicaid Program Created Inequities in Psychiatric Hospital Access for the Indigent Mentally Ill*, 29 AM. J. L. & MED. 159, 163 (2003) ("Medicaid is designed to improve healthcare for the poor by providing matching funds for state expenditures." Its purpose is to allow states to furnish medical assistance to families with dependent children, the aged, the blind, and the disabled, "whose income and resources are insufficient to meet the costs of necessary medical services.").

115. GAO REPORT, *supra* note 114.

116. FEDERAL MATCHING RATE AND MULTIPLIER—FY2009, KAISER STATE HEALTH FACTS, http://www.statehealthfacts.org/comparetable.jsp?ind=184&st=3&sort=1090. The rate at which a state is reimbursed by the federal government is based on a matching formula found in §1905(b) and §1101(a)(8)(B) of the Social Security Act. Social Security Act § 1905, 42 U.S.C. § 1396d (2006); Social Security Act § 1101, 42 U.S.C. §1301 (2006). Thus, the rate varies from state to state. The formula is based on a three-year average of the state's per-capita income compared to the national per-capita income. 42 U.S.C. § 1301(a)(8) (2006). The minimum is 50%, but can go to 70% or more. FEDERAL MATCHING RATE AND MULTIPLIER—FY 2009, KAISER STATE HEALTH FACTS, http://www.statehealthfacts.org/comparetable.jsp?ind=184&st=3&sort=1090. For FY 2009, Oregon's rate is 62.45%, Washington's is 50.94%, and California's is 50%. *Id.*

117. MARK ET AL., *supra* note 88, at v; GAO REPORT, *supra* note 114, at 2.

118. MARK ET AL., *supra* note 88, at v (from 1993 to 2003, state and local government spending increased from 31 percent to 40 percent of total substance abuse treatment funding, making it the largest financier of substance abuse treatment).

119. *Id.* at 39.

120. *Id.*

government general revenues, earmarked taxes (for example taxes on beer and wine[121]), fines and fees, and other sources of revenue.[122]

b. Funding Difficulties

Although funding has increased for substance abuse treatment in general and for pregnant and mothering substance abusers in particular, there still remain some difficulties because the funding level itself can be unstable. This is due, at least in part, to the fact that a major source of funding for the services is coming from the states.[123] Thus, in times of recession or economic crisis, the states face pressure that may lead to a reduction in spending for substance abuse treatment.[124] Oregon stands as a case in point. As the Governor's Council stated in its report:

> During its 2007 session, the Oregon Legislature took some encouraging initial steps to rebuild a system that had been decimated by budget cuts since 2001—those cuts coming at a time when the epidemic of methamphetamine use was reaching peak levels. Investments made in 2007 in treatment for vulnerable families, drug court clients, and prison populations are beginning to reap benefits that will pay economic and human dividends for decades to come. The same is true for the first significant effort to rebuild prevention efforts, which had been in decline for two decades. As encouraging as these steps may be, there is much still to be done to repair the damage done to Oregon's prevention, treatment and recovery efforts. Restoring the system to its status prior to cuts will not be adequate to address the need for a fully-funded and coordinated system that includes: prevention efforts, treatment services on demand, workforce development that attracts, trains and retains workers, and adequate housing for those in recovery.[125]

However, there is also no guarantee that the federal government will continue to fund programs for pregnant and postpartum women. This is demonstrated by the fact that although SAMHSA provided funds for treatment programs for pregnant, postpartum, and parenting women and their children in fiscal years 2007 and 2008,[126] for FY 2009, the program for pregnant and

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121. A source of funding for Oregon's substance abuse treatment services is the beer and wine tax. OR. REV. STAT.
§ 473.005–473.992 (2007).

122. Scanlon, *supra* note 112.

123. *See* notes 118–120 and accompanying text.

124. *See* MARK ET AL., *supra* note 88, at 60 (asking the question of "how will SA treatment programs that depend heavily on state and local funding fare during economic recessions that put pressure on state and local governments.").

125. OREGON GOVERNOR'S COUNCIL REPORT, *supra* note 50, at 38.

126. For FY 2007, CSAT awarded "11 supplemental grants to expand/enhance grant activities carried out under the Residential Treatment for Pregnant and Postpartum Women and Residential Treatment for Women and their Children Program funded in 2004. Grantees will expand the availability of comprehensive, high quality residential substance abuse treatment services for low-income women, age 18 and over, who are pregnant, postpartum women, or other parenting women, and their minor children, age 17 and under, who have limited access to quality health services. Each recipient will receive up to $500,000 per year for one year. Total funding is $5.4 million." CSAT DIRECTOR'S 2008 REPORT, *supra* note 109, at 33. In addition, in January of 2008, SAMHSA announced the availability of up to "$7.87 million to fund approximately 16 grants for three years to support

postpartum women is targeted for elimination.[127] Although this program may be restored by Congress in the final Appropriations Act as was done in FY 2008 for the programs that were recommended by the Director's Report for elimination or reduction,[128] there is no guarantee of such action.

3. External Barriers Confronted by Women in Accessing the Needed Services

For a woman who is using drugs or alcohol, any roadblock can deter her from seeking treatment. Thus, it is important to identify and, to the extent possible, eliminate any barriers to her accessing treatment. As will be demonstrated, the major external barriers that a woman faces in trying to obtain treatment services involve payment for the services, childcare, and logistics involved in accessing services and coordinating among various agencies.

a. Inability of Many Women to Access Funds to Pay for the Services

One barrier to accessing services involves paying for the services. The difficulty stems from the fact that treatment services are modeled on the provision of health services model as opposed to a social services model. Thus, it is not generally the case that the funding for the programs encompasses providing beds for clients free of charge (although some programs have sliding scales for payment that are based upon a person's earnings, e.g., the client pays $50 and the state pays the remainder). Rather, each individual woman is responsible for paying for the costs of the services from her own pocket or through health insurance-type funds provided by the state or the federal government. Because most of the women with whom this paper is concerned cannot pay from their own pockets, they have to attempt to match their situation with the eligibility requirements of the state or federal public insurance program. As a consequence, when a woman comes in for treatment, the program may receive payment from a variety of different sources, e.g., 80% from Medicaid and the other 20% from other sources. The various sources have different eligibility requirements and different documentation requirements. Therefore, finding funding for the woman's treatment may become unnecessarily complicated for both the woman and the provider, thus serving as a huge barrier to services.

A second barrier involves Medicaid itself. Given that Medicaid is one of the largest sources of funding for indigent women,[129] one would logically look to Medicaid to provide payment for treatment services. Unfortunately, there are

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residential treatment services for pregnant and postpartum women and their minor children, age 17 and under." *Id.* at 20.

127. CSAT DIRECTOR'S 2008 REPORT, *supra* note 109, at 3 (the report increased the SAPT Block Grant by approximately $20 million for a new provision to provide supplemental awards to the top 20 percent of states for superior performance and submission of data for the National Outcome Measures (NOMs). To support this increase, a number of programs, including the program for pregnant and postpartum women, were targeted for elimination).

128. *Id.* at 2.

129. *See* Cowell, *supra* note 88, at 177.

a variety of barriers to a woman in seeking payment for treatment services through Medicaid. For example, Medicaid coverage for substance abuse treatment is not mandated by federal law, thus, the states may choose to not provide reimbursement for such services.[130] Further, even if a state chooses to provide reimbursement for treatment services, it will only receive federal reimbursement if the patient is Medicaid-eligible and the treatment is provided under "a Medicaid service category that qualifies for federal matching funds."[131] Thus, a treatment might not be reimbursable because the service was social rather than medical treatment; the client was too old or too young to qualify; the provider was not Medicaid-qualified because it did not meet the definition of a medical practitioner; the facility provided room and board, which may not be reimbursed if provided in certain types of facilities; or the facility was too large.[132]

A facility being too large is a significant barrier to women seeking residential treatment.[133] This is due to the fact that Medicaid reimbursement for residential substance abuse treatment services is only available when provided in a treatment facility with a treatment capacity of sixteen beds or less. Such a facility is classified as an Institution of Medical Disease (IMD) and federal law prohibits Medicaid payments for services provided in an IMD.[134] The facility is classified as an IMD if it is a hospital, nursing facility, or other institution of more than sixteen beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."[135] Although federal law does not define alcohol and drug dependence as a mental disease, the Health Care Financing Administration ("HCFA")[136] has interpreted mental disease to include such dependence.[137] Although pregnant women are specifically allowed to obtain

130. GAO REPORT, *supra* note 114, at 2.

131. *Id*.

132. *Id*. at 3.

133. Tupper, *supra* note 90, at 333 (The IMD exclusion especially affects addicted mothers and severely addicted persons "by preventing Medicaid funds from reaching community-based residential treatment facilities with more than sixteen beds.").

134. 42 U.S.C. § 1396d(a)(28)(B) (West 2009) (stating that a medical assistance payment will not be made for care or services for any individual between the ages of 22 and 64 who is a patient in an institution of mental diseases); 42 CFR § 435.1009(a)(2) (West 2009) (stating that federal financial participation is not allowed for individuals aged 22 to 64 who are patients in an institution for mental diseases).

135. 42 U.S.C. §1396d(i) (West 2009).

136. Carole L. Stewart, Comment, *Mandated Medicaid Coverage Of Viagra: Raising The Issues of Questionable Priorities, The Need for A Definition of Medical Necessity, and the Politics of Poverty* , 44 LOY. L. REV. 611, 617 (1998) (citing 49 FR 35,247-01 & 35, 249-01, 1984 WL 122962 (F.R.) ("In 1984, the Secretary of the Department of Health and Human Services delegated his authority to carry out federal duties under the Medicaid statute to the Administrator of HCFA, a constituent agency within the Department of Health and Human Services. As a result, the HCFA was granted the authority to interpret the Medicaid statute and since then has regularly exercised that authority."); State of Louisiana v. U.S. Dep't. of HHS, 905 F.2d 877, 878 (5th Cir. 1990).

137. LEGAL ACTION CENTER, INCREASING ACCESS TO ALCOHOL AND DRUG TREATMENT AND PREVENTION SERVICES FOR PREGNANT AND POSTPARTUM WOMEN AND WOMEN WITH CHILDREN, 5 (1998), *available at* http://www.lac.org/doc_library/lac/publications/increasing_access_

Medicaid reimbursement for services,[138] there is no exception allowed for services in an IMD; unlike the exception provided for individuals 65 and over[139] and individuals under age 21.[140] Bills providing for such an exception were introduced in the Senate in 1990 and 1997, however, neither passed.[141] As a result of the IMD exclusion, even when a state chooses to cover treatment services for pregnant and mothering women under its Medicaid program, it will not cover residential services provided in an institution of more than sixteen beds.[142] The reason for this limitation is the belief of Congress that "long-term care in mental institutions was a state responsibility."[143]

A problem related to the Medicaid issues is the general instability of many funding sources. This is due to the fact that some sources dry up and others come into existence. As a result, a woman (or the program) has to determine what sources are still available and what new sources have been created. Then, with regard to these new sources, a woman (or the program) has to determine what the eligibility requirements are.

A third external barrier has been identified by Prof. Nekima Levy-Pounds. This barrier exists for the many women who may not access welfare benefits due to a lifetime ban placed upon persons convicted of committing drug offenses.[144] This ban was enacted as part of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA).[145] Since Levy-Pounds' article was written, however, The Sentencing Project updated their study[146] in 2006.[147] They found that many states are pulling back from that federal §115 ban[148] and thirty-five states and DC have eliminated or modified it.[149] Nonetheless, over 92,000 women remain affected by the lifetime ban, which subsequently impacts over 135,000 children.[150] With regards to the three sample states, Oregon has

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to_treatment.pdf; David F. Chavkin, *"For Their Own Good": Civil Commitment of Alcohol and Drug-Dependent Pregnant Women*, 37 SOUTH DAKOTA L. REV. 224, n.217 (1991/1992).

138. 42 U.S.C. § 1496d(a)(viii) (West 2009).

139. 42 U.S.C. § 1496d(a)(14) (West 2009).

140. 42 U.S.C. § 1496d(a)(17) (West 2009).

141. *See* Medicaid Drug Treatment for Families Act of 1990, S. 3002, 101st Cong., *available at* http://thomas.loc.gov/cgi-bin/query/z?c101:S.3002.IS; LEGAL ACTION CENTER, *supra* note 137 (The Medicaid Substance Abuse Treatment Act of 1997 would have lifted the IMD exclusion for pregnant and postpartum women, however, it did not pass).

142. *See, e.g.*, 22 CA. ADMIN. CODE TIT. 22 §51341.1(d)(4)(B) (West 2008) ("[P]erinatal residential substance abuse services shall be reimbursed through the Medi-Cal program only when provided in a facility with a treatment capacity of 16 beds or less, not including beds occupied by children of residents in accordance with Federal law.").

143. HARVEY L. MCCORMICK, 2 MEDICARE AND MEDICAID CLAIMS AND PROC. §23:6 (4th ed. 2008).

144. Nekima Levy-Pounds, *Beaten By the System and Down for the Count: Why Poor Women of Color and Children Don't Stand a Chance Against U.S. Drug-Sentencing Policy*, 3 U. ST. THOMAS L. J. 462, 489–94 (2006).

145. *Id.*

146. *Id.*

147. THE SENTENCING PROJECT, LIFE SENTENCES—DENYING WELFARE BENEFITS TO WOMEN CONVICTED OF DRUG OFFENSES STATE MODIFICATIONS UPDATE (April 2006), http://www.sentencingproject.org/Admin/Documents/publications/women_smy_lifesentences.pdf.

148. *Id.*

149. *Id.*

150. *Id.*

eliminated the ban completely, Washington eliminates the ban if the subject is receiving treatment, and California applies the ban for a limited term.[151]

Further, Levy-Pounds points out that The Public Health Service Act[152] can limit the ability of recovering women users to obtain housing.[153] This Act provides that the public housing authority can require access to criminal records and drug treatment information. The treatment information is limited to determining whether the drug treatment facility has reasonable cause to believe that the applicant is currently engaging in the illegal use of a controlled substance.[154] Although the public housing authority is not *required* to make these inquiries, if it does so for some it must do so for all.[155]

b. Lack of Childcare

In addition to funding, lack of childcare is a serious barrier to accessing treatment.[156] This is due to the fact that "70% of women entering treatment have children."[157] However, as previously discussed, out of the 13,648 mental health and substance abuse treatment facilities in existence in 2007,[158] for those whose primary focus is substance abuse only 760 provide childcare and only 410 have residential beds for clients' children.[159] Due to this scarcity of childcare, a large number of women simply will not be able attend treatment sessions.

c. Logistical Problems

In addition to the access problems outlined in subsections a and b, a barrier that often proves insurmountable is one simply of logistics. First, substance abusing pregnant and mothering women often have problems locating the programs and traveling to them. This is a particularly acute problem in rural areas. In terms of locating a treatment program, one source of difficulty is the number of different types of programs present in a city or region. To access these programs the woman must determine which programs are relevant for her needs and then find out whether these relevant programs have space for her. If there is space, then she has to find a way to travel to the program if it is any distance from her home.

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151. *Id.*

152. 42 U.S.C. §1437d (s)-(t) (West 2008).

153. Levy-Pounds, *supra* note 144, at 494.

154. *Id.*

155. *Id.*

156. Brady & Ashley, *supra* note 15, at 13.

157. D. Werner et al., *Family-Centered Treatment for Women with Substance Use Disorders-History, Key Elements and Challenges*, DEPARTMENT OF HEALTH AND HUMAN SERVICES, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION 1 (2007), *available at* http://womenandchildren.treatment.org/documents/Family_Treatment_Paper508V.pdf ("[C]ollaboration is an important element of family-centered treatment.").

158. OFFICE OF APPLIED STUDIES, U.S. DEP'T OF HEALTH AND HUMAN SERVS., NATIONAL SURVEY OF SUBSTANCE ABUSE TREATMENT SERVICES (N-SSATS) table 4.8, pp. 51–52 (2007).

159. OFFICE OF APPLIED STUDIES, U.S. DEP'T OF HEALTH AND HUMAN SERVS., NATIONAL SURVEY OF SUBSTANCE ABUSE TREATMENT SERVICES (N-SSATS) table 4.9, p. 53 (2007).

A second logistical problem exists because, in addition to addressing her substance abuse problem, the woman often has co-occurring problems that she must address.[160] These problems require that she attempt to work with the treatment provider, the child welfare department, the housing agency, and the mental health provider,[161] just to name a few. The complexities of attempting to juggle all of the above would prove to be too much for an average woman, and is likely to be that much more difficult for a woman who, more often than not, comes from a drug-abusing and disorganized family[162] and is often isolated from healthy support systems.[163] In Oregon, for example, this coordination of services is an ongoing problem.[164]

III. EVALUATION OF THE CURRENT LEGISLATION

Now that this article has demonstrated the nature of the problem, this section will evaluate the current state and federal legislation in the area to assess its ability to provide or facilitate the provision of comprehensive treatment services for pregnant and parenting women. It will then provide suggestions as to changes that can be made for implementation of the current legislation, as well as proposals for additional legislation and regulations.

A. Existing Legislation that Addresses Access to Programs

Beginning in the late 1980's and early 1990's, the federal government and the states began to again[165] recognize the need for programs that addressed the needs of women, and in particular, pregnant or mothering women. As will be outlined below, at that time and since then, both the states and the federal government have enacted different types of legislation in an attempt to provide treatment services for pregnant or mothering women.

1. Legislation Regarding the Creation of Appropriate Treatment Centers

As stated above, the largest source of funding for drug abuse treatment is state appropriations and SAPT block grants. Such monies have been used to create and expand existing treatment programs. With regard to federal funding

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160. *See supra* notes 21–23and accompanying text; MARY R. HAACK, *Comprehensive Community-Based Care: The Link between Public Policy and Public Health*, *in* DRUG-DEPENDENT MOTHERS AND THEIR CHILDREN, 1, 3 (Springer Publishing 1997) (the profile of the typical addicted women in treatment is that she is "a 27-31-year-old high school dropout with three or four children, either living in a drug-abusing environment, or homeless. She has been using illegal substances for at least 10 years, and has grown up in a home with violence, sexual abuse, and substance-abusing relatives.").

161. *Id.* at 21.

162. Jeanne C. Marsh et al., *Increasing Access and Providing Social Services to Improve Drug Abuse Treatment for Women With Children*, 95 ADDICTION 1237, 1238 (2000).

163. *Id. See also* Greenfield et al., *supra* note 12, at 15.

164. *See* OREGON GOVERNOR'S COUNCIL REPORT, *supra* note 50, at 3 ("Integrating planning, particularly between the Oregon Commission on Children and Families, the DHS Public Health Division and Addictions and Mental Health Division are a significant planning and public policy problem that needs to be addressed.").

165. As outlined previously, programs began to be developed in the late 1970s and early 1980s to address the treatment needs of this population. *See supra* notes 59–62 and accompanying text. However, these funding sources dried up. *Supra* note 61.

in general, Part B of the Public Health Service Act[166] authorizes the Secretary of Health and Human Services to make a grant to a state for "the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse."[167] In addition to the general funding provision, the statute also mandates that a specific percentage of grant monies go to create new programs or expand existing programs to increase the availability of programs for pregnant women and women with dependent children.[168] Further, as part of the funding agreement, any entity providing treatment services with these monies must (directly or through arrangements with other public or nonprofit private entities) "make available prenatal care to women receiving such services and, while the women are receiving the services, childcare."[169]

Such legislation enabled the funding of several demonstration projects that created new programs for pregnant and mothering women that are still in existence today or that served as models for current programs. For example, the Pregnant and Postpartum Women and Infants (PPWI) and Residential Women and Children (RWC) programs were created with SAPT money.[170] Under these programs, 147 demonstration projects took place between 1989 and 1992 that were financed by SAPT money through the federal Center for Substance Abuse Treatment (CSAT).[171] CSAT, along with SAMHSA, promotes the quality and availability of community-based substance abuse services. [172] To do this, CSAT works with state and community-based groups to improve and expand existing substance abuse services under the SAPT block grant program. [173] In accordance with CSAT's mission, the PPWI and RWC demonstration projects focused upon developing community-based models of drug prevention, education, and treatment for pregnant and mothering substance abusers and their children.[174] The projects also provided direct services for the relevant population, including "case management, parenting classes, and referrals to drug and alcohol

166. 42 U.S.C.A. §300x-21(b) (West 2008).

167. *Id*.

168. 42 U.S.C.A. §300x-22(b)(1)(a)-(c) (West 2008) ("[T]he State involved will (a) expend not less than 5 percent of the grant to increase (relative to fiscal year 1992) the availability of treatment services designed for pregnant women and women with dependent children (either by establishing new programs or expanding the capacity of existing programs);(b) in the case of a grant for fiscal year 1994, the State will expend not less than 5 percent of the grant to so increase (relative to fiscal year 1993) the availability of such services for such women; and (c) in the case of a grant for any subsequent fiscal year, the State will expend for such services for such women not less than an amount equal to the amount expended by the State for fiscal year 1994.").

169. 42 U.S.C.A. §300x-22 (West 2008).

170. PREVENTION OF PERINATAL SUBSTANCE USE: PREGNANT AND POSTPARTUM WOMEN AND THEIR INFANTS DEMONSTRATION GRANT PROGRAM. ABSTRACTS OF ACTIVE PROJECTS FY 1993, NATIONAL MATERNAL AND CHILD HEALTH CLEARINGHOUSE (1993) [hereinafter PREVENTION OF PERINATAL SUBSTANCE USE](explaining the 147 demonstration projects); Lucy Salcido Carter & Carol S. Larson, *Drug Exposed Infants*, 7 THE FUTURE OF CHILDREN 157, 158 (1997), http://www.futureofchildren.org/usr_doc/vol7no2ART11.pdf.

171. PREVENTION OF PERINATAL SUBSTANCE ABUSE, *supra* note 170; Carter & Larson, *supra* note 170, at 158.

172. CSAT, Center for Substance Abuse Treatment, http://csat.samhsa.gov/mission.aspx.

173. *Id*.

174. PREVENTION OF PERINATAL SUBSTANCE USE, *supra* note 170.

programs."[175] In addition to the above projects, CSAT used SAPT block grants to fund residential treatment projects in 1993.[176] The two projects were under the Residential Treatment Grants for Pregnant and Postpartum Women and Their Infants (PPWI) and the Residential Treatment Grants for Women and Their Children (RWC) programs (see above).[177] Under these two projects, 74 residential programs were funded in 1996 and 65 residential programs were funded in 1997.[178] A study of 50 of these residential drug treatment programs explained that the grants were used as seed money for programs that targeted women with "long-standing problems of compulsive, out-of-control substance abuse, usually coupled with other significant problems."[179] The study found that such an approach worked well to create additional treatment services because all but three of the 50 programs were able to continue operating using mainly state funds, with some supplemental funding provided by further federal or foundation grants.[180]

With regard to state legislation, some states put in place mechanisms for creating programs designed specifically to meet the needs of the pregnant or mothering substance abuser.[181] In addition, a small number of states enacted legislation that created pilot programs that are designed to serve pregnant

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175. *Id.*

176. Carter & Larson, *supra* note 170, at 158.

177. *Id.* at 159.

178. *Id.*

179. BENEFITS OF RESIDENTIAL SUBSTANCE ABUSE TREATMENT FOR PREGNANT AND PARENTING WOMEN, HIGHLIGHTS FROM A STUDY OF 50 DEMONSTRATION PROGRAMS OF THE CENTER FOR SUBSTANCE ABUSE TREATMENT (2001), http://csat.samhsa.gov/ publications/residential/ residential_background.aspx.

180. *Id.*

181. GUTTMACHER INSTITUTE, STATE POLICIES IN BRIEF, SUBSTANCE ABUSE DURING PREGNANCY 1 (2009), http://www.guttmacher.org/pubs/spib_SADP.pdf [hereinafter GUTTMACHER INSTITUTE] (19 states have either created or funded drug treatment programs specifically targeted to pregnant women). *See, e.g.*, ARIZ. REV. STAT. ANN. §8-812 (Westlaw 2008) (providing for the creation of a fund to pay for treatment services for addicted parents to help them to quickly get back custody) and ARIZ. REV. STAT. ANN. §36-141 (Westlaw 2008) (in allocating money for treatment programs, priority is to be given for treatment svcs for pregnant abusers of alcohol and other drugs); COLO. REV. STAT. ANN. §25-1-212 (Westlaw 2008) (creation of a treatment program for high-risk pregnant women who abuse drugs or alcohol; COLO. REV. STAT. ANN. §25-1-213 (Westlaw 2008) (outlines the necessary components of such a program); CONN. GEN. STAT. ANN. §17a-710 (Westlaw 2008) (policy to develop and implement comprehensive treatment programs for substance-abusing women and their children); KAN. STAT. ANN. §65-1,165 (Westlaw 2008) (directs the secretary of social and rehabilitation services to ensure that family oriented substance abuse treatment is available); LA. REV. STAT. ANN. §46:2505 (Westlaw 2008) ("The Department of Health and Hospitals shall establish a program to provide addictive disorders services to eligible pregnant women. Such services shall ensure the availability of appropriate addictive disorders treatment programs that do not discriminate against pregnant women or women with young children."); VERNON'S ANN. MISSOURI STAT. §191.731 (Westlaw 2008) (directing the division of alcohol and drug abuse programs to ensure that family-oriented substance abuse treatment is available; mandating that a pregnant woman referred for substance abuse treatment be a "first-priority user" of available treatment; and prohibiting publicly funded treatment programs from refusing to treat pregnant women); WIS. STAT. ANN. §46.86 (Westlaw 2008) (provides for the allocation of funds for special treatment and recovery programs).

women.[182] For example, out of our three target states, California enacted legislation authorizing the creation of a comprehensive pilot program.[183] Similarly, Washington used legislation to create a model project for mothes of drug or alcohol exposed infants. [184] In addition, Washington enacted a statute mandating the development and expansion of comprehensive services for pregnant and mothering women.[185]

2. Legislation Regarding Access to Existing Treatment Programs

In addition to legislation concerning the creation of appropriate treatment programs, there also is legislation designed to improve access to the programs that exist. Some of the legislation stems from the regulations accompanying the SAPT block grant legislation that require the states to put in place a system that is designed to maximize the ability of a pregnant woman to receive treatment.[186] In response to these regulations, some states mandated that treatment centers give priority to pregnant substance abusers or not discriminate against pregnant substance abusers.[187] Other states provided mechanisms for coordinating

182. *See, e.g.*, KY. REV. STAT. ANN. §222.037 (Westlaw 2008) ("The Cabinet for Health and Family Services may establish four or more pilot projects within the Commonwealth to demonstrate the effectiveness of different methods of providing community services to prevent smoking and alcohol and substance abuse by pregnant females"); OKLA. STAT. ANN. §1-546.4 (Westlaw 2008) (authorizes the implementation of a pilot project for addicted pregnant women).

183. WEST'S CAL. WLF. & INST. CODE §11757.59 (2008).

184. REV. CODE WASH. §13.34.800 (2008).

185. REV. CODE WA.§13.34.803 (requires "the departments of health and social and health services to develop a comprehensive plan for services for mothers who have delivered a drug or alcohol-exposed or affected infant, and who meet the definitions of an at-risk eligible person and who have a child up to three years of age"); REV. CODE WA.§13.34.390 (requiring the department of social and health services and the department of health to develop and expand comprehensive services for drug-affected and alcohol-affected mothers and infants).

186. 45 C.F.R. §§ 96.131(c) (2008) ("The State shall in carrying out paragraph (a) of this section require that, in the event that a treatment facility has insufficient capacity to provide treatment services to any such pregnant woman who seeks the services from the facility, the facility refer the woman to the State. This may be accomplished by establishing a capacity management program, utilizing a toll-free number, an automated reporting system and/or other mechanisms to ensure that pregnant women in need of such services are referred as appropriate. The State shall maintain a continually updated system to identify treatment capacity for any such pregnant women and will establish a mechanism for matching the women in need of such services with a treatment facility that has the capacity to treat the woman.").

187. Steverson, *Prenatal Drug Exposure*, *supra* note 1, at 48. *See* GUTTMACHER INSTITUTE, *supra*, note 181, at 1 ("9 states provide pregnant women with priority access to state-funded treatment programs"). *See, e.g.*, GA. CODE ANN. §§26-5-5 & 26-5-20 (Westlaw 2008) (directing the children's welfare department to promulgate "criteria for providing priority in access to services and admissions to programs for drug dependent females," and requiring all drug treatment programs to "implement a priority admissions policy for the treatment of drug dependent females which provides for immediate access to services for any such female applying for admission"); KAN. STAT. ANN. §65-1,165-(a) (Westlaw 2008) ("A pregnant woman referred for substance abuse treatment shall be a first priority user of substance abuse treatment available through social and rehabilitation services." Further, "substance abuse treatment facilities which receive public funds shall not refuse to treat women solely because they are pregnant."); KY. REV. STAT. ANN. §222.037 (providing authority to create four pilot programs to demonstrate the effectiveness of, *inter alia*, "linking with community services and treatment for the chemically dependent woman, her children, and other family members; and gaining access to early intervention services for infants in need"); MO. ANN.

services among various agencies to better meet the needs of pregnant or mothering substance abusers.[188] Others attempted to address only the issue of outreach.[189] At least one state, Illinois, attempted to address both problems by directing the coordination of services for pregnant and mothering substance abusers, while also putting in place mechanisms for reaching out to the affected women.[190] It did so, however, only for pregnant substance abusers, not mothering substance abusers.[191]

Finally, some states have enacted legislation designed to better enable substance abusing pregnant women to pay for treatment services. For example, Arizona enacted legislation which mandated that, using monies appropriated for temporary assistance for needy families (TANF), the Department of Economic Security must provide funding to the Department of Health Services for "perinatal substance abuse treatment and services for persons whose family income does not exceed two hundred per cent of the federal poverty guidelines as published by the United States Department of Health and Human Services."[192] In our target states, California has enacted extensive regulations designed to provide services for pregnant and postpartum substance abusing women. Specifically, the regulations indicate that California's public health insurance, Medi-Cal, is to provide reimbursement at enhanced perinatal rates

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STAT. §191.731 (Westlaw 2008) (mandating that a pregnant woman referred for substance abuse treatment be a "first-priority user" of available treatment; and prohibiting publicly funded treatment programs from refusing to treat pregnant women).

188. *See, e.g.*, WEST'S SMITH-HURD ILL. COMP. STAT. ANN. §301/35-5 (Westlaw 2008) (provides for the coordination of services among the various agencies for serving addicted pregnant women, mothers, and their children who are affected by alcoholism and other drug abuse or dependency); Ind. P.L. 193-2007, Sec. 5, eff. July 1, 2007 (codified at IND. ST. §12-23-14.5-1 (Westlaw 2008)) (establishing the prenatal substance abuse commission "to develop and recommend a coordinated plan to improve early intervention and treatment for pregnant women who abuse alcohol or drugs or use tobacco."); 7 OKLA. STAT. ANN. §1-546.4 (Westlaw 2008) (provides mechanisms for removing barriers for services, including treatment, for addicted pregnant women); 1 PA. CONS. STAT. ANN. §553 (a) (Westlaw 2008) (directing the Department of Health to find the means to provide residential drug and alcohol treatment and related services for pregnant women, mothering women, and women who have lost custody of their children, but who have a reasonable likelihood of regaining custody by participating in the treatment program); REV. CODE WA.§13.34.803 (requires "the departments of health and social and health services to develop a comprehensive plan for services for mothers who have delivered a drug or alcohol exposed or affected infant, and who meet the definitions of at-risk eligible person and who have a child up to three years of age"); WIS. STAT. ANN. §46.86 (allocation of funds for multidisciplinary prevention and treatment teams).

189. ME. REV. STAT. TIT. 22, §§4011-B, 4004-B (Westlaw 2008) (creates an obligation that health care providers report suspected cases of prenatal exposure; however, such notification is to only be used only by the child welfare department to investigate, assess, and refer the child or mother or both to social service agency or substance abuse prevention service); NEV. REV. STAT. ANN. 432B.220 (Westlaw 2008) (provides that certain mandatory reporters are required to report suspected cases of prenatal drug exposure to the child welfare department, but the department is not to investigate if the problem can be eliminated by referral to or participation in appropriate services).

190. WEST'S SMITH-HURD ILL. COMP. STAT. ANN. §301/35-5 (provides for the coordination of services among the various agencies in order to serve addicted pregnant women and provides that a referral to the Department of Human Services of a substance abusing pregnant woman will result only in the Department preparing a case management plan and assisting the pregnant woman in obtaining counseling and treatment).

191. Steverson, *Prenatal Drug Exposure*, *supra* note 1, at 48.

192. ARIZ. REV. STAT. ANN. §46-300.04 (Westlaw 2008).

for certified providers who provide specified substance abuse services to pregnant and postpartum women.[193] The services include different types of treatment services (narcotic treatment, outpatient treatment, day care habilitative services, and residential treatment), as well as perinatal services (mother-child habilitative and rehabilitative services, provision of or arrangement for transportation to and from medically necessary treatment, education, and the coordination of ancillary services such as dental services, community services, educational/vocational training and other services medically necessary to prevent risk to the fetus or infant).[194] In addition, Washington regulations created the chemical-using pregnant (CUP) women program[195] which "provides immediate access to medical care in a hospital setting to chemical-using or chemical-dependent pregnant women and their fetuses" in order to "reduce harm to and improve birth outcomes for mothers and their fetuses."[196] Finally, Oregon has regulations concerning the Pregnant Substance Abusing Women and Women with Young Children (PWWC) Targeted Case Management (TCM) Program.[197] The rules are "designed to assist the TCM provider in matching state and federal funds for TCM services."[198] Further, the TCM rules "explain the Oregon Medicaid Program for reimbursing PWWC TCM services."[199] "This TCM program improves access to needed medical, social, education and other services to Medicaid eligible women living in [five specified] counties."[200]

3. Legislation Regarding Recovery Services

In examining the relevant legislation and regulations, although the authors found the above legislation pertaining to treatment services and access to such services, they did not find much specific reference to recovery services. They did find that the federal legislation and corresponding regulations to the SAPT block grant program require the states to establish a housing fund with block grant funds.[201] The funds are to be used to support group homes for recovering substance abusers.[202] Specifically, to make loans for the costs of establishing programs for the provision of housing where recovering addicts may reside in groups of not less than six individuals.[203] The legislation requires that at least $100,000 be available for the fund and the loans (1) must not exceed $4,000 [see sub§4]; (2) must be repaid by residents not later than two years from the date on which the loan is made [see sub§ 4]; and (3) must be repaid by residents in

193. 22 CA. ADMIN. CODE, tit. 22 § 51341.1 (c)(1) (Westlaw 2008).
194. 22 CA. ADMIN. CODE, tit. 22 § 51341.1(d) (Westlaw 2008).
195. WA. ADMIN. CODE § 388-533-0701 (Westlaw 2008).
196. *Id*.
197. OR. ADMIN. REG. 410-138-0500.
198. *Id*.
199. *Id*.
200. *Id*.
201. 45 CFR § 96.129 (the state shall establish and maintain the ongoing operation of a revolving fund to support group homes for recovering substance abusers.). *See also* 42 U.S.C.A. § 300x-25.
202. 42 U.S.C.A. §300x-25.
203. *Id*.

monthly installments with a penalty for late payments [see sub§ 5].[204] Finally, the entity receiving the loan has to agree that alcohol and illegal drug use is prohibited in the housing, that violators will be thrown out, that residents will pay the cost of housing, including fees for rent and utilities, and that the residents will establish policies to govern residence in the group home.[205]

In addition to federal legislation, the state of Oregon has focused upon the recovery aspect of treatment services quite strongly in recent years. Thus, the Governor's Council Report could state that, due to the efforts of the Legislature and Executive Branch, progress toward meeting the need for sufficient recovery housing has been made.[206]In particular, the Oregon government realized that recovering addicts need safe, affordable and drug-free housing to aid in the recovery process.[207] This realization led the government to implement three alcohol and Drug Free (ADF) housing initiatives in the years 1999–2001.[208] Thus, a 2005 AMH housing survey found that the state had 4,600 people with substance abuse disorders living in "supportive, structured or specialized residential settings.[209] This was made possible, in part, by 27 new housing projects with a capacity of 500 that were created in the years 2000 through 2005.[210] In addition, in the specific areas of self-governed, peer support recovery homes, Oregon now has 150 such homes accommodating 1,200 recovering individuals.[211] The Governor's Council has urged the state to expand the above efforts.[212]

B. Evaluation of the Legislation and Suggestions for Change

The overview in section II.B. of funding sources for substance abuse treatment demonstrates that, due to at least two factors, the states have a great deal of control over the provision of appropriate services. First, although a large percentage of funding for substance abuse treatment services comes from the federal government, the federal legislation places very few limits upon the states' decisions in this area.[213] Second, for the majority of states, the greatest percentage of funding comes from state sources and, of course, the state controls how its own funds are spent. In spite of this control, the preceding overview of the state legislation demonstrates that the states have generally not taken advantage of their flexibility by putting in place a comprehensive plan for addressing the treatment needs of pregnant and parenting women.[214] This section will identify the gaps in the legislation and provide proposals for closing those gaps. The section will also address the question of funding.

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204. *Id*.
205. *Id*.
206. OREGON GOVERNOR'S COUNCIL REPORT, *supra* note 50, at 36.
207. *Id*.
208. *Id*.
209. *Id*.
210. *Id*.
211. *Id*. at 37.
212. *Id*. at 36.
213. *Supra* note 94 and accompanying text.
214. Steverson, *Prenatal Drug Exposure*, *supra* note 1, at 48–49.

1. A Comprehensive Plan

The overview of the legislation demonstrates that a slight majority of states (26) have put in place some type of mechanism for addressing the need for treatment services for pregnant and parenting women.[215] However, a large minority of the states and the District of Columbia still have no legislation concerning the creation of treatment services or priority for pregnant women. Further, in addition to the target states of California and Washington, the authors found only two other states, Illinois and Wisconsin, that have attempted to create a comprehensive plan for the provision of appropriate services.[216] However, the states cannot simply rely on providers to create the necessary programs. The state needs to take the lead and provide mandates and guidance for its single state authority. This authority can then, in turn, provide mandates and guidance to the treatment providers. Further, with regard to the additional services that pregnant and mothering women need, only the state can orchestrate the necessary coordination among the agencies and providers that furnish these services.

The first step in creating comprehensive legislation is for the state to obtain a clear picture of its needs and its resources pertaining to pregnant and mothering women. There are a variety of mechanisms that a state can utilize to

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215. A total of 26 states have legislation in place which creates a targeted program for pregnant substance abusers and/or gives priority for treatment to pregnant substance abusers and/or protecting pregnant women from discrimination in publicly funded programs. GUTTMACHER INSTITUTE, *supra*, note 181, at 2 (also noting that the Guttmacher Institute includes Oregon as a state creating a targeted program, however, the authors do not consider legislation that establishes "requirements for health care providers to encourage and facilitate drug counseling" as the creation of a targeted program). Out of these 26 states, four provide only for priority access, Georgia, Texas, Utah and Wisconsin. GUTTMACHER INSTITUTE, *supra*, note 181, at 2. One state provides only for nondiscrimination, Iowa. *Id.* Two states provide for priority access and nondiscrimination, Kansas and Oklahoma. *Id.* Sixteen states provide for only the creation of targeted programs: Arkansas, California, Colorado, Connecticut, Florida, Illinois, Kentucky, Louisiana, Minnesota, Nebraska, New York, North Carolina, Ohio, Pennsylvania, Virginia and Washington. *Id.* Two states provide for targeted programs and priority access, Arizona and Maryland. *Id.* Finally, one state provides for targeted programs, priority access, and nondiscrimination, Missouri. *Id.*

216. Illinois has enacted a number of provisions under §301/35-5 that are designed to "promote a comprehensive, statewide and multidisciplinary approach to serving addicted pregnant women and mothers, including those who are minors, and their children who are affected by alcoholism and other drug abuse or dependency." As part of this effort, with "funds appropriated expressly for the purposes of this Section, the Department shall create or contract with licensed, certified agencies to develop a program for the care and treatment of addicted pregnant women, addicted mothers and their children," as well as programs for low income addicted pregnant women. WEST'S SMITH-HURD ILL. COMP. STAT. ANN. §301/35-5. In addition, Illinois provides that the annual comprehensive State plan that reports on the state alcohol and dependency treatment programs shall contain a report detailing the activities of and progress made by the programs for the care and treatment of addicted pregnant women, addicted mothers and their children established under subsection 35-5 of §301. WEST'S SMITH-HURD ILL. COMP. STAT. ANN. §301/5-10. Finally, Illinois provides for the coordination of services among the various agencies in order to serve addicted pregnant women and provides that a referral to the Department of Human Services of a substance abusing pregnant woman will result only in the Department preparing a case management plan and assisting the pregnant woman in obtaining counseling and treatment. WEST'S SMITH-HURD ILL. COMP. STAT. ANN. §301/35-5.

Although not as comprehensive as Illinois' legislation, Wisconsin has legislation that provides for the allocation of funds for special treatment and recovery programs and the allocation of funds for multidisciplinary prevention and treatment teams. WIS. STAT. ANN. §46.86.

obtain this picture, but one that is quite effective is the creation of a task force to evaluate the state's needs. An example of such a task force is the 2006 Arkansas Task Force on Substance Abuse Treatment Services.[217] Once the state has a clear picture of its needs, it can create legislation or regulations for the creation of appropriate programs. The state should include in the legislation or regulations guidance to the state's treatment providers concerning the necessary components of a comprehensive treatment program. The task force can inform the state as to whether the above should be effectuated through detailed legislation alone or through broad legislation with detailed regulations.[218]

In determining the necessary components of a comprehensive treatment program, the state has a number of resources. First, the discussion in section II of this article outlines the types of programs that are needed. Further, the states of Connecticut and Illinois have legislation that can serve as a model.[219] Finally, both the Department of Health and Human Services and the National Association of State Alcohol and Drug Abuse Directors have recently published documents that can serve as good models for the types of programs that are needed. [220]

These resources indicate that the first component of any program is the creation of appropriate treatment services. It is not sufficient for a state to provide priority access to treatment programs if those programs are unable to address the unique needs of pregnant and mothering women. In particular, the states need to establish programs that are designed specifically for pregnant and mothering women. At least some of these programs need to be residential programs. These residential programs need to allow a mother to avoid separation from her children. As was explained previously, such is necessary because many women will not seek treatment if it involves separation from their children. Further, research indicates that treatment is more effective when mother and child are together.[221] A related component is, of course, the provision of childcare services for those women who are not in residential treatment.

A second component of the comprehensive program is the provision of recovery services. All of the evidence suggests that, without recovery services, we are simply wasting our money on providing treatment services to those who will return to the exact same environment that helped foster their drug addiction. Of particular importance then is the creation of additional funding to create the necessary housing. The funding provided for in the SAPT legislation is a start, however, the fund appears to be of limited utility, given how small the amount of the loan is. It is difficult to see how someone can establish and maintain a program with only $4,000. Thus, the states need to come up with

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217. TASK FORCE ON SUBSTANCE ABUSE TREATMENT SERVICES, http://staging.arkleg.state.ar.us/data/Substance%20Treatment%5C2006%5Creport1114-2006.doc.

218. *See id*. at 8 (outlining the pros and cons of legislation versus regulation).

219. CONN. GEN. STAT. ANN. §17a-710 (Westlaw 2008); WEST'S SMITH-HURD ILL. COMP. STAT. ANN. §301/35-5.

220. GUIDANCE TO States, *supra* note 13; D. Werner et al., *supra* note 157, at 2. ("[C]ollaboration is an important element of family-centered treatment.").

221. Steverson, *Prenatal Drug Exposure*, *supra* note 1, at 51.

their own mechanisms for funding recovery housing. In addition to creating housing, the states need to continue the trend of lifting the lifetime ban on welfare benefits that was outlined above.

A third component of the comprehensive program would encompass either the creation of one-stop-shopping programs, or given that such is often not feasible, some type of triage center. A woman can then visit this center and learn her eligibility for different types of public insurance (the authors use this term to apply to all sources of funding that do not include private insurance– private insurance encompasses Health Maintenance Organization (HMOs), preferred provider organizations (PPOs) & other types of private insurance). She can then be matched with centers that meet all of her necessary requirements: (1) they can provide the needed services; (2) they have space available; and (3) they accept her funding sources.

Finally, collaboration and coordination is needed between the multiple systems in which client families are often involved.[222] These systems include child welfare, criminal justice, and social services. [223] Such social services can include employment programs, TANF, food stamps, crisis support programs, mental health services, general health services, victims of domestic violence assistance services, housing and homeless service agencies, and child development and education services.[224] Wisconsin provides an example of legislation that could begin to accomplish this collaboration through its allocation of funding for the creation of multidisciplinary prevention and treatment teams.[225] In addition, Illinois provides for the coordination of services among the various agencies in order to serve addicted pregnant women.[226]

2. Funding

One of the largest problems in providing access to comprehensive treatment programs for pregnant and mothering women is a lack of adequate funding. As the overview of legislation demonstrated, both the federal government and the state governments have enacted legislation to attempt to address the issue of funding, both for the creation of programs and for payment for services. An in-depth look at all of the possible mechanisms for increasing funding is beyond the scope of this article. Thus, the authors will simply point to areas of concern. For a more comprehensive look at funding strategies, the reader should consult the Department of Health and Human Services' recent paper describing funding streams that are available to fund family treatment programs or components of those programs.[227] This paper also provides

222. D. Werner et al., *supra* note 157, at 2.

223. *Id*.

224. *Id*. at 27–28.

225. WIS. STAT. ANN. §46.86 (West 2008).

226. WEST'S SMITH-HURD ILL. COMP. STAT. ANN. §301/35-5.

227. Dennis et al., *Funding Family-Centered Treatment for Women with Substance Use Disorders*, DEPARTMENT OF HEALTH AND HUMAN SERVICES, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION 2, (2008).

suggestions to States and substance abuse treatment providers concerning ways in which to strengthen their financial strategies.[228]

One area of concern with regard to funding with federal government monies is the inadequacy of the SAPT funding to provide for a sufficient number of long-term residential comprehensive treatment programs.[229] An additional concern is the proposed elimination of the program for pregnant and postpartum women.[230] Given the continuing unmet need for pregnant and mothering women, cutting programs is not appropriate at this time. If the government needs to save money, then it could refocus the program from residential treatment to enhanced outpatient treatment. As explained previously, the research indicates that, except for severely dependent women, enhanced outpatient treatment can be just as effective as residential treatment.[231] Further, enhanced outpatient treatment is much less costly than residential treatment. [232]

An additional area of concern regarding funding involves Medicaid. First, the IMD exclusion is hampering the provision of residential treatment services in ways that were unintended. Consequently, Congress needs to eliminate the exclusion, at least as it pertains to the provision of residential treatment of substance abuse. In addition, the rates for Medicaid reimbursement to treatment providers need to be increased in order to encourage more providers to treat Medicaid-eligible women. For example, California regulations require reimbursement at enhanced perinatal rates for certified providers who provide specified substance abuse services to pregnant and postpartum women.[233] Further, the states that have not yet done so should eliminate the lifetime ban on welfare benefits.

A third area of concern is the inadequacy and instability of state funding. The state's role as the major source of monies for substance abuse treatment programs indicates that it needs to increase and stabilize its revenue sources for such programs.[234] Again, an in-depth analysis of the very complicated question of how to increase revenue sources for state government is beyond the scope of this paper.[235]

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228. D. Werner et al., *supra* note157, at i.

229. Tupper, *supra* note 90, at 351.

230. *See supra* note 127 and accompanying text.

231. *See supra* notes 26–28 and accompanying text.

232. *See* Wallace, *supra* note 26, at 25 (enhanced outpatient "may be preferable and more cost effective").

233. 22 CA. ADMIN. CODE, tit. 22 § 51341.1(c)(1) (Westlaw 2008).

234. *See supra* note 125 and accompanying text concerning the difficulties currently being created because the largest portion of funding for substance abuse treatment comes from state and local governments and the majority of this funding is from a state's general fund.

235. A good source of information for the states on this topic is Kimberly Dennis et al., *Funding Family-Centered Treatment for Women With Substance Use Disorders*, OFFICE OF PROGRAM ANALYSIS AND COORDINATION, CENTER FOR SUBSTANCE ABUSE TREATMENT, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA) 1 (2008), http://www.samhsa.gov.

IV. CONCLUSION

Federal and state legislation has improved access to comprehensive alcohol and drug treatment services for some pregnant and mothering women. Unfortunately, systemic barriers still prevent significant numbers of pregnant and mothering women from obtaining the services that they need to overcome their alcohol or drug dependency. These barriers include insufficient treatment programs with women or pregnant women-focused services, an inability on the part of the women to pay for those services that do exist, and an inability to access appropriate programs due to logistical issues such as lack of coordination among service providers, limited transportation and little access to child care. To help alleviate these barriers each state must first determine what unmet need exists among its population. It then needs to enact legislation or regulations that mandate the creation of comprehensive treatment programs to meet that need. The necessary components of the comprehensive treatment program include appropriate treatment services, recovery services, ancillary services and mechanisms to easily allow the target women to access all necessary services.